

On October 14, 2003 the Office accepted appellant's claim for left metacarpal-third finger fracture and left knee sprain. The Office authorized surgery on October 2, 2003 to repair the fracture.

In an October 2, 2003 report, Dr. Perry Inhofe, a Board-certified orthopedic surgeon and appellant's treating physician, advised that he had a left hand long finger metacarpal fracture and laceration of the extensor digitorum communis tendon to the long finger and presented for operative intervention to repair the fracture. Appellant received compensation benefits and returned to modified duty on October 22, 2003.

On February 17, 2004 Dr. Inhofe performed manipulation under anesthesia of the left hand. Appellant subsequently returned to full-time light duty on February 23, 2004.

In an April 5, 2004 report, Dr. Inhofe advised that appellant came in for follow up concerning his hand and was released to return to full duty without restrictions. He indicated that appellant had reached maximum medical improvement.

On April 9, 2004 appellant filed a claim for a schedule award.

By letter dated April 23, 2004, the Office advised appellant that he needed to obtain a report from his physician describing whether he had any impairment and if so, the percentage of impairment with an explanation of how the calculation was derived.

In a May 12, 2004 report, Dr. Inhofe noted appellant's history of injury and treatment and utilized the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment*. He advised that following a metacarpal fracture appellant underwent appropriate rehabilitation management and had reached maximum medical improvement and was fully released. Dr. Inhofe indicated that appellant had a 10 percent impairment of the left hand, with no permanent restrictions.

In a July 16, 2004 report, an Office medical adviser indicated that Dr. Inhofe found a 10 percent impairment of the left hand but did not provide any details as to how he arrived at the impairment estimate. The Office medical adviser requested that Dr. Inhofe be contacted to furnish an explanation of his calculations.

By letter dated July 29, 2004, the Office requested that Dr. Inhofe provide an assessment of permanent impairment with an explanation of how he made his determination under the A.M.A., *Guides*. In an August 4, 2004 report, Dr. Inhofe explained his calculations. He advised that appellant had a clinical grip strength of 75 pounds in the left hand and 105 pounds in the right hand. He referred to Table 16-34¹ and determined that this represented impairment to grip strength of 28 percent. Dr. Inhofe advised that this would equate to an upper extremity impairment of 10 percent.

¹ A.M.A., *Guide* at 509, Table 16-34.

In an August 30, 2004 report, the Office medical adviser noted the accepted conditions of fracture or left long finger metacarpal left strain/sprain and tear of the left lateral knee cartilage. He advised that Dr. Inhofe provided an explanation of his evaluation on May 12, 2004. The Office medical adviser indicated that appellant had grip strength in the left hand of 75 pounds or 34.1 kilograms and 105 pounds on the right or 47.7 kilograms. He subtracted the 47.7 kilograms from the 34.1 and divided by 47.7 kilograms. The Office medical adviser arrived at a 28.5 strength loss index yielding a 10 percent impairment. He indicated that this was a valid calculation. However, the Office medical adviser advised that under Chapter one of the A.M.A., *Guides*, the claimant must be at maximum medical improvement. Furthermore, he advised that pursuant to section 16.8a,² maximal strength was not regained for at least one year following the time of injury or surgery. The Office medical adviser opined that strength loss could only be used as an indicator for impairment when one year or more had passed since the time of injury or surgery. He requested that Dr. Inhofe reevaluate appellant's strength one year post surgery or October 2004.

By letter dated September 13, 2004, the Office advised appellant that maximal strength was not regained for at least one year following surgery and that he needed to be reevaluated by his physician in October 2004, which was one year following surgery.

On October 18, 2004 appellant filed a claim for a schedule award.

In support of his claim, appellant submitted an October 4, 2004 report from Dr. Inhofe, who advised that he returned for a follow-up examination and indicated that he demonstrated the ability to passively close his hand into a fist. He noted that appellant could only actively get 75 percent of motion at the small and ring finger and 85 percent motion at the long. Dr. Inhofe indicated that the index could touch the tip of the nail to proximal palmar crease, but not the distal palmar crease. He provided grip strength measurements for both hands.

By decision dated November 2, 2004, the Office denied appellant's claim for a schedule award.³ The Office advised him that his file was reviewed by the Office medical adviser, who determined that appellant had not submitted a report from his physician reevaluating his strength one year following the surgery.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act⁴ sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions, and organs of the body.⁵ The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results

² A.M.A., *Guides* at 508, 16.8a.

³ It appears that this decision only dealt with appellant's claim for a schedule award to the upper extremity.

⁴ 5 U.S.C. §§ 8101-8193.

⁵ 5 U.S.C. § 8107.

and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.⁶ The A.M.A., *Guides* has been adopted by the implementing regulation as the appropriate standard for evaluating schedule losses.⁷

ANALYSIS

In the instant case, Dr. Inhofe provided an October 4, 2004 report with updated findings regarding appellant's grip strength. The Board notes that this report is one year post surgery. Dr. Inhofe provided this subsequent report as directed by the Office and utilized the A.M.A., *Guides*. In the November 2, 2004 decision, the Office advised appellant that the Office medical adviser had reviewed the file and determined that the evidence did not demonstrate any ratable impairment. However, it appears that the Office merely referenced the August 30, 2004 report of the Office medical adviser; there is no indication that the Office fully considered the report from Dr. Inhofe, which was one year post surgery. As appellant provided an updated report in conjunction with the schedule award request, the Office should have considered these findings and submitted them to the Office medical adviser in an effort to determine whether he was entitled to a schedule award. Office procedures regarding schedule awards indicate that, after all necessary medical evidence is obtained, the case file must be routed to the Office medical adviser for an opinion concerning the nature and percentage of impairment.⁸ Accordingly, the Board will remand the case to the Office for appropriate further medical development with regard to the claim for a schedule award for the arm.

CONCLUSION

The Board finds that this case is not in posture for decision and must be remanded for further medical development.

⁶ *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

⁷ 20 C.F.R. § 10.404.

⁸ Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6 (August 2002).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated November 2, 2004 is set aside and the case is remanded for further development consistent with this opinion

Issued: May 18, 2005
Washington, DC

Alec J. Koromilas
Chairman

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member